PBP 2002 DATA ENTRY INSTRUCTIONS

INTRODUCTION

The Plan Benefit Package (PBP) software is composed of the PBP Management Screen and four sections: A, B, C, and D. These sections collect data concerning general organization and plan information, benefits descriptions, access and dual eligible information, and premium and optional supplemental benefits information, respectively.

Based on comments received from MCOs and changes in Medicare policy, HCFA has modified the PBP to improve the collection and display of the data for plan year 2002. This document highlights the changes made for PBP2002 and clarifies PBP issues raised in 2001.

PBP SOFTWARE FEATURES

Part A/B Plans versus Part B Only Plans

Inpatient hospital and SNF services are not covered by Medicare for Part B Only beneficiaries. Therefore, the data collected in these benefit categories for the Part B Only plans differs from that data collected for the Part A/B plans.

Red versus Blue Variables

Data variables in the PBP are either red or blue. A red variable indicates that this information will be used to generate the Standardized Summary of Benefits (SB) sentences that are used in marketing materials and in Medicare Compare (MCC). Blue variables do not impact either the SB or MCC.

Help

The PBP2002 has Help features throughout the system. At any time, by right clicking the mouse, the variable help, directions, and definitions can be accessed. System Help is available by pressing the <F1> key.

PBP 2002 CONTENT/POLICY CLARIFICATIONS AND CHANGES

This section highlights software changes between PBP2001 and PBP2002, and also provides HCFA policy clarifications for completing the PBP2002.

Content Changes

Cost Share Amounts

Cents can now be entered with dollars in all fields that collect monetary amounts, including Copayments, Deductibles, Maximum Plan Benefit Coverage, Maximum Enrollee Out-of-Pocket Costs, and Premium amounts.

Point-of-Service (POS)

The explicit Point of Service screens for each service category have been eliminated. Also, the questions regarding whether the plan offers a point-of-service benefit have been moved from Section A to Section B-19. This new location corresponds to Health Component #19 in the ACR. This section will not be enabled if the plan type is HMO.

Visitor/Travel (V/T) Benefit

In Section A of the PBP2002, the plan must indicate if it includes a V/T program; and, if a V/T benefit is included, the MCO must describe the program in the Section A Notes. The detailed information collected in the PBP2001 has been eliminated.

Referral versus Authorization

In PBP2002, the question, "Is a referral required for …?" has been added in most service categories, and the SB sentences concerning referrals will be generated from these questions. Generally, a referral is defined as an actual document obtained from a provider in order for the beneficiary to receive additional services, whereas, authorization is defined as notification or approval to receive a service. In the PBP2001, questions concerning authorization produced the SB referral sentences.

Policy Clarifications and Changes

Maximum Plan Benefit Coverage

Maximum Plan Benefit Coverage is only applicable for service categories where there are enhanced benefits being offered by the plan, because Medicare coverage does not allow a Maximum Plan Benefit Coverage expenditure limit.

Coinsurance versus Discount

When entering cost sharing information, discounts should be entered as coinsurance and not described in the Notes. For example, if an MCO offers a discount of 20% for prescription drugs, provided that this is a benefit with a direct cost in the ACR, then the MCO should enter a 80% coinsurance in the PBP. This will display the appropriate information in the Summary of Benefits.

Minimum/Maximum Cost Shares

Throughout the PBP, minimum/maximum (min/max) cost sharing amounts are collected. Min/max cost sharing questions exist in certain categories because the cost sharing for an item or service could vary. When a min/max cost share is required, the SB sentence that is generated will display either the range of cost sharing values or the single cost share amount. For example, if the min/max fields are filled out as $0 and $5, the SB sentence generated will read, "You pay $0 to $5 for….". If the min/max fields both contain $5, the SB sentence generated will read, "You pay $5 for….".

Periodicity

Periodicity within the PBP is generally presented as five or six options, including every six months, every year, every two years, etc. Although this accommodates many plan

benefit structures, it cannot accommodate all structures. Therefore, HCFA has provided for an "other" periodicity to be entered. If the benefit plan periodicity is not specifically listed, i.e., every 18 months, the option "other" should be selected. HCFA has made changes in the SB sentences when the option "other" is selected that provides language which is more appropriate. See the SB 2002 crosswalk for this language.

Zero Cost Share Values

In the PBP2002, if there is no cost sharing for benefits in a category, i.e., no coinsurance and no copayment, the questions "Is there an enrollee Coinsurance?" and "Is there an enrollee Copayment?" should both be answered "No". By answering "No" to both these questions, the PBP will generate the following SB sentence, "There is no copayment for [particular service]". If the MCO wants to generate the sentence "You pay $0 for [particular service]", then the MCO should answer the copayment question "Yes" and enter a "0" for the copayment amount. In the PBP2001, MCOs had to enter $0 for copayment in order to generate a sentence in the SB stating that there was no copayment.

Optional Supplemental Benefits

Information on Optional Supplemental Benefits will be displayed both in the standardized Summary of Benefits and Medicare Compare. This information will include the premium associated with the optional benefits package and the benefit categories included in that package. Specific details concerning the optional benefits (i.e., cost shares, maximum plan benefit coverage, etc.) will not be displayed.

Step-ups

If a plan offers multiple levels of a benefit, i.e., a basic benefit and an elevated version (a.k.a. a step-up), then one version of the benefit should be entered in the Notes field of the benefit category.

Specifically, if an enhanced benefit is offered as both an Additional or Mandatory Supplemental and as an Optional Supplemental benefit, the Additional or Mandatory Supplemental benefit should be described in the data fields within the PBP service category. The Optional Supplemental benefit should be described entirely in the Notes field for that service category. NOTE: The MCO should NOT describe or enter Step-up benefits in PBP Service Categories B-13c, B-13d, or B-13e.

Alternatively, if the plan offers only Optional Supplemental benefits at different levels, i.e, the benefit is not offered as an Additional or Mandatory Supplemental benefit, then the plan must enter one Optional Supplemental benefit in the service category data fields and describe the other Optional Supplemental benefit in the Notes field.

Example: Prescription drugs are offered as a Mandatory Supplemental benefit with a maximum limit of $500 per year. The MCO also offers Prescription Drugs as an Optional Supplemental benefit with a limit of $1500 per year. To describe these two benefits, the MCO should complete the Outpatient Prescription Drug screens describing the benefit with the $500 limit. The Optional Supplemental benefit with a $1500 limit

should be described entirely in the Notes field in service category B-15. Be sure to include all information. Please refer to Section D in this document for information on packaging and pricing the Optional Supplemental benefits.

PBP 2002 SECTION AND SERVICE CATEGORY ISSUES

SECTION A

Information contained in Section A consists primarily of high level MCO and Plan information, including the H and Plan ID numbers, type of plan, name of the plan, geographic area of the plan, and data entry contact information. This data has two sources: HPMS and the PBP. Many data elements in Section A are downloaded from HPMS after the MCO has "created" a plan. These data elements are then displayed as disabled ("grayed out") in Section A of the PBP.

SECTION B

B-1a: Inpatient Hospital—Acute

The Inpatient Hospital Acute subcategory has changed significantly in the PBP2002. An additional enhanced benefit has been added for a Non-Medicare-covered Stay. In addition, the cost sharing has been modified to allow plans to enter self-designated intervals for costs per day. Below are the instructions for entering data if a plan has cost sharing on a per day basis.

Medicare Covered Stay Cost Shares: If a plan has a per day cost structure for Medicare-covered stays, the plan must explicitly price the 90 days covered by Medicare during a benefit period. To ensure this pricing structure, the software requires the user to enter, at a minimum, a start day equal to '1' in the first interval, and an end day equal to '90' in the last interval. Note that the end day can be entered in the first, second, or third interval, depending upon the plan's cost structure.

Example: If a MCO charges $100 per day with a maximum of $500 per stay, the MCO should declare two intervals and enter the copayment as $100 for Days 1 through 5 and $0 for Days 6 through 90.

NOTE: Medicare's lifetime reserve days are not explicitly described in the cost-sharing, since the use of lifetime reserve days is at the discretion of the beneficiary and not assigned by the plan. Any information concerning lifetime days should be described in the Notes section of Inpatient Hospital Acute.

Additional Days Cost Shares: Additional days are defined as days covered by the plan after the 90 Medicare-covered days per benefit period. Additional days for Inpatient

Hospital Acute should always start at day 91. The number of additional days offered will determine the end day.

Example: If 10 additional days per benefit period are offered, then the cost share structure should specify additional days 91 through 100. If an unlimited number of additional days are offered, "999" should be used to notate the end day of the pricing structure. By using "999", the SB will generate a sentence that states "You pay $x for additional days 91 and beyond."

Non-Medicare Covered Stay Cost Shares: A non-Medicare-covered stay is a stay that is not medically necessary and reasonable according to Medicare coverage guidelines, or is provided in a facility not certified by Medicare. If the plan has a per day cost share for the Non-Medicare-covered stay, the first day of the cost share interval must be day 1 and the last day must be the maximum number of days covered under the benefit. As in the case of the Medicare-covered stay, all days must be explicitly priced for the non-Medicare covered stay, if a per day cost share structure exists.

Example: If the plan charges $50 per day for an unlimited Non-Medicare-covered Stay, then the MCO should declare one interval and enter $50 for days 1 through 999.

If the Medicare Covered cost-sharing and Non-Medicare Covered cost sharing are the same, answer "Yes" to the question, "Is the Copayment [Coinsurance] structure for the Non-Medicare Covered stay the same as the Copayment [Coinsurance] structure for the Medicare Covered stay?". By answering "Yes", the correct SB sentences will be produced, eliminating unneeded duplication of sentences.

General issue concerning Inpatient Substance Abuse:
Inpatient Substance Abuse may be covered either under Inpatient Hospital Acute or Inpatient Psychiatric Hospital. The MCO may use either subcategory to describe it in the PBP.

B-1b: Inpatient Hospital—Psychiatric

The Inpatient Psychiatric Hospital subcategory has also changed significantly in the PBP2002. An additional enhanced benefit has been added for a Non-Medicare-covered Stay. Cost sharing has been modified to allow plans to enter self-designated intervals for costs per day. Below are the instructions for entering data if a plan has cost sharing on a per day basis.

Medicare Covered Stay Cost Shares: If a plan has a per day cost structure for Medicare-covered stays, the plan must explicitly price the 190 days covered by Medicare. To ensure this pricing structure, the software requires the user to enter, at a minimum, a start day equal to '1' in the first interval, and an end day equal to '190' in the last interval. Note

that the end day can be entered in the first, second, or third interval, depending upon the plan's cost structure.

Example: If a MCO charges $100 per day with a maximum of $500 per stay, the MCO should declare two intervals and enter the copayment as $100 for Days 1 through 5 and $0 for Days 6 through 190.

Additional Days Cost Shares: Additional days are defined to be days covered after the 190 Medicare-covered days. Additional days for Inpatient Psychiatric Hospital should always start at day 191. The number of additional days offered will determine the end day.

Example: If 10 additional days per benefit period are offered, then the cost share structure should specify additional days 191 through 200. If an unlimited number of additional days are offered, "999" should be used to notate the end day of the cost share structure. By using "999", the SB will generate a sentence that states "You pay $x for additional days 191 and beyond."

Non-Medicare Covered Stay Cost Shares: A non-Medicare-covered stay is a stay that is not medically necessary and reasonable according to Medicare coverage guidelines, or is provided in a facility not certified by Medicare. If the plan has a per day cost share for the Non-Medicare-covered stay, the first day of the cost share interval must be day 1 and the last day must be the maximum number of days covered under the benefit. As in the case of the Medicare-covered stay, all days must be explicitly priced for the non-Medicare covered stay, if a per day cost share structure exists.

Example: If the plan charges $50 per day for an unlimited Non-Medicare-covered Stay, then the MCO should declare one interval and enter $50 for days 1 through 999.

If the Medicare Covered cost-sharing and Non-Medicare Covered cost sharing are the same, answer "Yes" to the question, "Is the Copayment [Coinsurance] structure for the Non-Medicare Covered stay the same as the Copayment [Coinsurance] structure for the Medicare Covered stay?". By answering "Yes", the correct SB sentences will be produced, eliminating unneeded duplication of sentences.

General issue concerning Inpatient Substance Abuse:
Inpatient Substance Abuse may be covered either under Inpatient Hospital Acute or Inpatient Psychiatric Hospital. The MCO may use either subcategory to describe it in the PBP.

B-2: Skilled Nursing Facility (SNF)

The Skilled Nursing Facility subcategory has changed significantly in the PBP2002. An additional enhanced benefit has been added for a Non-Medicare-covered Stay. Cost

sharing has been modified to allow plans to enter self-designated intervals for costs per day. Below are the instructions for entering data if a plan has cost sharing on a per day basis.

Medicare Covered Stay Cost Shares: If a plan has a per day cost structure for Medicare-covered stays, the plan must explicitly price the 100 days covered by Medicare during a benefit period. To ensure this pricing structure, the software requires the user to enter, at a minimum, a start day equal to '1' in the first interval, and an end day equal to '100' in the last interval. Note that the end day can be entered in the first, second, or third interval, depending upon the plan's cost structure.

Example: If a MCO charges $100 per day with a maximum of $500 per stay, the MCO should declare two intervals and enter the copayment as $100 for Days 1 through 5 and $0 for Days 6 through 100.

Additional Days Cost Shares: Additional days are defined to be days covered after the 100 Medicare-covered days per benefit period. Additional days for SNF should always start at day 101. The number of additional days offered will determine the end day.

Example: If 10 additional days per benefit period are offered, then the cost share structure should specify additional days 101 through 110. If an unlimited number of additional days are offered, “999” should be used to notate the end day of the pricing structure. By using “999”, the SB will generate a sentence that states “You pay $x for additional days 101 and beyond.”

Non-Medicare Covered Stay Cost Shares: A non-Medicare-covered stay is not medically necessary and reasonable according to Medicare coverage guidelines, or is provided in a facility not certified by Medicare. If the plan has a per day cost share for the Non-Medicare-covered stay, the first day of the cost share interval must be day 1 and the last day must be the maximum number of days covered under the benefit. As in the case of the Medicare-covered stay, all days must be explicitly priced for the non-Medicare covered stay, if a per day pricing structure exists.

Example: If the plan charges $50 per day for an unlimited Non-Medicare-covered Stay, then the MCO should declare one interval and enter $50 for days 1 through 999.

If the Medicare Covered cost-sharing and Non-Medicare Covered cost sharing are the same, answer "Yes" to the question, “Is the Copayment [Coinsurance] structure for the Non-Medicare Covered stay the same as the Copayment [Coinsurance] structure for the Medicare Covered stay?”. By answering “Yes”, the correct SB sentences will be produced, eliminating unneeded duplication of sentences.

General issue concerning Skilled Nursing Facility:
Medicare requires a prior 3 day inpatient hospital stay and an admission to a SNF within 30 days of the inpatient discharge, to be a qualifying SNF stay. If the MCO admits a

beneficiary who does not meet these requirements to a SNF, it is a non-Medicare covered SNF stay and must be described and priced accordingly in the PBP and ACR as an Additional, Mandatory or Optional Supplemental benefit.

B-3: Comprehensive Outpatient Rehabilitation Facility (CORF)

No major changes have been made in the CORF category. Data should be entered as was done for PY2001.

B-4a: Emergency Care/Post Stabilization Care

For PBP2002, there is a clarification and a new SB sentence for a cost share that is waived upon immediate admittance from the ER to the hospital. MCOs often waive the coinsurance and/or copayment for the emergency room visit if a beneficiary is admitted to the hospital. If the cost share is waived, the question "Is the Coinsurance [Copayment] for Medicare Covered Benefits waived if admitted to hospital?" should be answered "Yes" and the appropriate days or hours in which the admission must occur for the waiver should be entered. If the waiver is only applicable when the beneficiary is immediately admitted to the hospital, then "hours" should be selected and the number "0" should be entered as the number of hours in which admittance must occur for the cost-sharing to be waived. This will produce the sentence, "You do not pay this amount if you are immediately admitted to the hospital."

B-4b: Urgently Needed Care/Urgent Care Centers

For PBP2002, there is a clarification and a new SB sentence for a cost share that is waived upon immediate admittance to the hospital. MCOs often waive the coinsurance and/or copayment for the urgent care center visit if a beneficiary is admitted to the hospital. If the cost share is waived, the question "Is the Coinsurance [Copayment] for Medicare Covered Benefits waived if admitted to hospital?" should be answered "Yes" and the appropriate days or hours in which the admission must occur for the waiver should be entered. If the waiver is only applicable when the beneficiary is immediately admitted to the hospital, then "hours" should be selected and the number "0" should be entered as the number of hours in which admittance must occur for the cost-sharing to be waived. This will produce the sentence, "You do not pay this amount if you are immediately admitted to the hospital."

B-5: Partial Hospitalization

No major changes have been made in the Partial Hospitalization category. Data should be entered as was done for PY2001.

B-6: Home Health Services

No major changes have been made in the Home Health category. Data should be entered as was done for PY2001.

B-7a: Primary Care Physician Services

No major changes have been made for the PBP2002 in the Primary Care Physician Services category. Data should be entered as was done for CY2001.

B-7b: Chiropractic Services

Medicare Covered Chiropractic Services only include Manual Manipulation of the Spine to Correct Subluxation. Any other Chiropractic Services that are offered would be considered routine care and would be classified as either Additional, Mandatory Supplemental, or Optional Supplemental benefits.

Significant changes have been made in the Summary of Benefits. Manual Manipulation of the Spine and Chiropractic Services (Routine care) have been merged into one category, "Chiropractic Services". The SB sentences will continue to distinguish between the Manual Manipulation of the Spine and Routine Care.

B-7c: Occupational Therapy Services

No major changes have been made for the PBP2002 in the Occupational Therapy Services category. Data should be entered as was done for CY2001. However, as noted in the description of the benefit, the moratorium on the $1500 cap for therapy services has been extended to December 31, 2002.

B-7d: Physician Specialist Services

No major changes have been made for the PBP2002 in the Physician Specialist Services category. Data should be entered as was done for CY2001.

B-7e: Mental Health Specialist Services

The Mental Health Specialist Services subcategory has changed significantly in the PBP2002. Cost sharing has been modified to allow plans to enter self-designated

intervals for costs per visit. Below are the instructions for entering data if a plan has cost sharing on a per visit basis.

Individual/Group Visit Cost Shares: If a plan has a per visit cost structure for individual and/or group visits, the plan should explicitly price these visits. Since the visits are Medicare-covered, the plan should enter a start visit equal to '1' in the first interval, and an end visit equal to '999' in the last interval. Note that the end visit can be entered in the first, second, or third interval, depending upon the plan's cost structure.

Example: If an MCO charges $10 per visit for the first 10 visits, then $25 per visit for all visits beyond 10, the MCO should declare two intervals and enter the copayment as $10 for Visits 1 through 10 and $25 for Visits 11 through 999.

Example: If an MCO charges $10 per visit for the first 10 visits, then $25 per visits 11-20, then 50% coinsurance for all visits beyond 20, the MCO should declare three intervals for both copayment and coinsurance. The copayment intervals would be $10 for Visits 1 through 10, $25 for Visits 11 through 20, and $0 for Visits 21 through 999. The coinsurance intervals would be 0% for Visits 1 through 10, 0% for Visits 11 through 20, and 50% for Visits 21 through 999. This structure will ensure proper sentences print out in the SB.

If the cost sharing for both individual and group visits are the same, ensure that the cost sharing structure is entered exactly the same for both the individual and group visits. By doing so, one SB sentence will be produced for both types of visits, thereby eliminating unnecessary duplication.

B-7f: Podiatry Services

Medicare Covered Podiatry Services only include medically necessary and reasonable foot care. Any other Podiatry Services that are offered would be considered routine care and would be classified as either Additional, Mandatory Supplemental, or Optional Supplemental benefits.

Significant changes have been made in the Summary of Benefits. Medically Necessary Foot Care and Podiatry Services (Routine care) have been merged into one category, “Podiatry Services”. The SB sentences will continue to distinguish between the Medically Necessary Foot Care and Routine Care.

B-7g: Other Health Care Professional Services

No major changes have been made for the PBP2002 in the Other Health Care Professional Services category. Data should be entered as was done for CY2001.

B-7h: Psychiatric Services

The Psychiatric Services subcategory has changed significantly in the PBP2002. Cost sharing has been modified to allow plans to enter self-designated intervals for costs per visit. Below are the instructions for entering data if a plan has cost sharing on a per visit basis.

Individual/Group Visit Cost Shares: If a plan has a per visit cost structure for individual and/or group visits, the plan should explicitly price these visits. Since the visits are Medicare-covered, the plan should enter a start visit equal to '1' in the first interval, and an end visit equal to '999' in the last interval. Note that the end visit can be entered in the first, second, or third interval, depending upon the plan's cost structure.

Example: If a MCO charges $10 per visit for the first 10 visits, then $25 per visit for all visits beyond 10, the MCO should declare two intervals and enter the copayment as $10 for Visits 1 through 10 and $25 for Visits 11 through 999.

Example: If an MCO charges $10 per visit for the first 10 visits, then $25 per visits 11-20, then 50% coinsurance for all visits beyond 20, the MCO should declare three intervals for both copayment and coinsurance. The copayment intervals would be $10 for Visits 1 through 10, $25 for Visits 11 through 20, and $0 for Visits 21 through 999. The coinsurance intervals would be 0% for Visits 1 through 10, 0% for Visits 11 through 20, and 50% for Visits 21 through 999. This structure will ensure proper sentences print out in the SB.

If the cost sharing for both individual and group visits are the same, ensure that the cost sharing structure is entered exactly the same for both the individual and group visits. By doing so, one SB sentence will be produced for both types of visits, thereby eliminating unnecessary duplication.

B-7i: Physical Therapy and Speech-Language Pathology Services

No major changes have been made for the PBP2002 in the Physical Therapy and Speech-Language Pathology Services category. Data should be entered as was done for CY2001. However, as noted in the description of the benefit, the moratorium on the $1500 cap for therapy services has been extended to December 31, 2002.

B-8a: Outpatient Clinical/Diagnostic/Therapeutic Radiological Lab Services

No major changes have been made for the PBP2002 in the Outpatient Clinical/Diagnostic/ Therapeutic Radiological Lab Services category. Data should be entered as was done for CY2001.

B-8b: Outpatient X-Rays

No major changes have been made for the PBP2002 in the Outpatient X-Rays Services category. Data should be entered as was done for CY2001.

B-9a: Outpatient Hospital Services

No major changes have been made for the PBP2002 in the Outpatient Hospital Services category. Data should be entered as was done for CY2001.

B-9b: Ambulatory Surgical Center Services

No major changes have been made for the PBP2002 in the Ambulatory Surgical Center Services category. Data should be entered as was done for CY2001.

B-9c: Outpatient Substance Abuse Services

The Outpatient Substance Abuse Services subcategory has changed significantly in the PBP2002. Cost sharing has been modified to allow plans to enter self-designated intervals for costs per visit. Below are the instructions for entering the cost share structure if a plan has cost sharing on a per visit basis.

Individual/Group Visit Cost Shares: If a plan has a per visit cost structure for individual and/or group visits, the plan should explicitly price these visits. Since the visits are Medicare-covered, the plan should enter a start visit equal to '1' in the first interval, and an end visit equal to '999' in the last interval. Note that the end day can be entered in the first, second, or third interval, depending upon the plan's cost structure.

Example: If a MCO charges $10 per visit for the first 10 visits, then $25 per visit for all visits beyond 10, the MCO should enter the copayment as $10 for Visits 1 through 10 and $25 for Visits 11 through 999.

Example: If an MCO charges $10 per visit for the first 10 visits, then $25 per visits 11-20, then 50% coinsurance for all visits beyond 20, the MCO should declare three intervals for both copayment and coinsurance. The copayment intervals would be $10 for Visits 1 through 10, $25 for Visits 11 through 20, and $0 for Visits 21 through 999. The coinsurance intervals would be 0% for Visits 1 through 10, 0% for Visits 11 through 20, and 50% for Visits 21 through 999. This structure will ensure proper sentences print out in the SB.

If the cost sharing for both individual and group visits are the same, ensure that the cost sharing structure is entered exactly the same for both the individual and group visits. By doing so, one SB sentence will be produced for both types of visits, thereby eliminating unnecessary duplication.

B-9d: Cardiac Rehabilitation Services

No major changes have been made for the PBP2002 in the Cardiac Rehabilitation Services category. Data should be entered as was done for CY2001.

B-10a: Ambulance Services

No major changes have been made for the PBP2002 in the Ambulance Services category. Data should be entered as was done for CY2001.

B-10b: Transportation Services

No major changes have been made for the PBP2002 in the Transportation Services category. Data should be entered as was done for CY2001.

If transportation services are not offered, the category will not appear on the SB.

B-11a: DME

No major changes have been made for the PBP2002 in the DME Services category regarding the data entry screens. However, a new category, Diabetes Monitoring Supplies, has been added (see category B-11c). Since the new category for diabetes monitoring supplies has been added, benefit information contained in the DME Services category includes all DME not related to Diabetes Monitoring Supplies.

B-11b: Prosthetics and Medical Supplies

The Prosthetics and Medical Supplies category has not changed significantly for the PBP2002. However, the SB category has been changed from “Prosthetics Devices and Medical Supplies” to “Prosthetics Devices”. Since the SB category is specifically aimed at Prosthetic Devices, data entry must be modified in order to produce an accurate SB sentence.

For the PBP2002, data entered in the cost sharing fields of category 11b-Prosthetics and Medical Supplies should only include data for Prosthetic Devices. Cost-sharing information for Medical Supplies should be entered in the Notes Fields.

Example: If an MCO charges 20% for Prosthetics and no cost sharing for Medical Supplies, 20 should be entered for the minimum coinsurance amount and 20 should be entered for the maximum coinsurance amount. In the Notes field of category 11b, the MCO should state "there is no copayment/coinsurance for Medical Supplies."

B-11c: Diabetes Monitoring Supplies

A new category, Diabetes Monitoring Supplies has been added to the PBP2002. This category has been added to distinguish between Diabetes Monitoring Supplies and other DME, since cost sharing often differs between these two categories. Benefit information for Diabetes Training should continue to be entered in category 14i-Diabetes Monitoring. SB sentences will distinguish between Diabetes Monitoring Training and Diabetes Monitoring Supplies.

B-12: Renal Dialysis

No major changes have been made for the PBP2002 in the Renal Dialysis Services category. Data should be entered as was done for CY2001.

B-13a: Outpatient Blood

No major changes have been made for the PBP2002 in the Outpatient Blood Services category. Data should be entered as was done for CY2001.

B-13b: Acupuncture

No major changes have been made for the PBP2002 in the Acupuncture Services category. Data should be entered as was done for CY2001.

If acupuncture services are not offered, the category will not appear on the SB.

B-13c: Other1

The category, "Other1" should be used to describe benefits that are not provided for in other areas of the PBP, such as a massage benefit. This category should not be used to provide information on benefits that are listed in other areas such as the Hepatitis B

vaccine. In addition, optional supplemental benefits and "step-ups" (see section on policy clarifications and changes for step-ups) should not be described in this category.

B-13d: Other2

The category, "Other2" should be used to describe benefits that are not provided for in other areas of the PBP, such as a massage benefit. This category should not be used to provide information on benefits that are listed in other areas such as the Hepatitis B vaccine. In addition, optional supplemental benefits and "step-ups" (see section on policy clarifications and changes for step-ups) should not be described in this category.

B-13e: Other3

The category, "Other3" should be used to describe benefits that are not provided for in other areas of the PBP, such as a massage benefit. This category should not be used to provide information on benefits that are listed in other areas such as the Hepatitis B vaccine. In addition, optional supplemental benefits and "step-ups" (see section on policy clarifications and changes for step-ups) should not be described in this category.

B-14a: Health Education/Wellness

Health Education/Wellness has had no major changes for the PBP2002. However, if an MCO offers a Fitness Center benefit but does not charge a copay or coinsurance for this benefit, the "Other" box in B-14a should be selected instead of selecting the Fitness Center box. In many instances, an MCO will provide a reimbursement or an allowance to beneficiaries for their participation in a fitness club. Since this benefit is included without a coinsurance or copayment, the SB would read as if the Fitness Center benefit is of absolutely no cost to the beneficiary. Therefore, by selecting the "Other" enhanced benefit, no misleading information will be provided to the beneficiary and the benefit information concerning the Fitness Center benefit can be described in Section 3 of the SB.

If no Health Education/Wellness services are not offered, the category will not appear on the SB.

B-14b: Immunizations

No major changes have been made for the PBP2002 in the Immunizations Services category. Data should be entered as was done for CY2001. The Immunization category on the SB does include some automatically generated sentences (see SB2002 Crosswalk).

If there is no cost sharing for immunizations but a doctor office copayment does or may apply, the coinsurance/copayment questions for immunizations should be marked “No” while the question, “Indicate whether a separate office visit cost share applies for services:” should be marked either “Yes” or “Sometimes, describe”. Multiple copay sentences will not be generated in the SB provided the cost sharing for the immunization is marked "No."

B-14c: Routine Physical Exam

No major changes have been made for the PBP2002 in the Routine Physical Exam Services category. Data should be entered as was done for CY2001.

B-14d: Pap and Pelvic Exams

This category collects information about preventive services covered by Medicare and offered by the plan. Diagnostic services that are covered by Medicare are not included in this category. The enhanced benefits in this category reflect preventive services offered by the plan in addition to those covered by Medicare.

If there is no cost sharing for Pap and Pelvic Exams but a doctor office copayment does or may apply, the coinsurance/copayment questions for Pap and Pelvic Exam should be marked “No” while the question, “Indicate whether a separate office visit cost share applies for services:” should be marked either “Yes” or “Sometimes, describe”. Multiple copay sentences will not be generated in the SB, provided the cost sharing for the Pap and Pelvic Exams is marked "No."

B-14e: Prostate Cancer Screening

This category collects information about preventive services covered by Medicare and offered by the plan. Diagnostic services that are covered by Medicare are not included in this category. The enhanced benefits in this category reflect preventive services offered by the plan in addition to those covered by Medicare.

If there is no cost sharing for Prostate Cancer Screenings but a doctor office copayment does or may apply, the coinsurance/copayment questions for Prostate Cancer Screening should be marked “No” while the question, “Indicate whether a separate office visit cost share applies for services:” should be marked either “Yes” or “Sometimes, describe”. Double copay sentences will not be generated provided the cost sharing for the Prostate Cancer Screening is marked "No."

B-14f: Colorectal Cancer Screening

This category collects information about preventive services covered by Medicare and offered by the plan. Diagnostic services that are covered by Medicare are not included in this category. The enhanced benefits in this category reflect preventive services offered by the plan in addition to those covered by Medicare.

If there is no cost sharing for Colorectal Cancer Screenings but a doctor office copayment does or may apply, the coinsurance/copayment questions for Colorectal Cancer Screening should be marked “No” while the question, “Indicate whether a separate office visit cost share applies for services:” should be marked either “Yes” or “Sometimes, describe”. Multiple copay sentences will not be generated in the SB, provided the cost sharing for the Colorectal Cancer Screening is marked "No."

B-14g: Bone Mass Measurement

This category collects information about preventive services covered by Medicare and offered by the plan. Diagnostic services that are covered by Medicare are not included in this category.

If there is no cost sharing for Bone Mass Measurements but a doctor office copayment does or may apply, the coinsurance/copayment questions for Bone Mass Measurement should be marked “No” while the question, “Indicate whether a separate office visit cost share applies for services:” should be marked either “Yes” or “Sometimes, describe”. Multiple copay sentences will not be generated in the SB, provided the cost sharing for the Bone Mass Measurement is marked "No."

B-14h: Mammography Screening

This category collects information about preventive services covered by Medicare and offered by the plan. Diagnostic services that are covered by Medicare are not included in this category. The enhanced benefits in this category reflect preventive services offered by the plan in addition to those covered by Medicare.

If there is no cost sharing for Mammography Screening but a doctor office copayment does or may apply, the coinsurance/copayment questions for Mammography Screening should be marked “No” while the question, “Indicate whether a separate office visit cost share applies for services:” should be marked either “Yes” or “Sometimes, describe”. Multiple copay sentences will not be generated in the SB, provided the cost sharing for the Mammography Screening is marked "No."

B-14i: Diabetes Monitoring

Diabetes Monitoring, 14i, is specifically designed for diabetes monitoring training. Diabetes supplies should be entered in category 11c, Diabetes Monitoring Supplies.

B-15: Outpatient Prescription Drugs

The Outpatient Prescription Drugs category in the PBP2002 has several changes. In response to plans that indicated that they do not offer non-formulary drugs unless it is medically necessary, a new question has been added. If the plan indicates that non-formulary drugs are not offered, then another question is enabled that asks the plan if non-formulary drugs are provided ONLY if medically necessary. The plan should select "Yes" or "No", and may describe any details in the Notes field. Answering "Yes" to this question does not require any further data entry for non-formulary drugs.

Also, another set of questions has been added to enable a plan to describe a limit on the entire drug benefit. If the plan indicates that it has a maximum plan benefit coverage, then the plan must designate if there is an overall limit, a limit on a combination of drug types, and/or limit(s) on individual drug types.

Example: The plan offers Formulary (Brand and Generic) drugs and has a $500 annual limit on Brand and unlimited Generic drugs. The plan would designate that it has a maximum plan benefit coverage, and that this includes Individual drug types. Under Formulary-Brand, the plan would indicate that there is a maximum plan benefit coverage of $500 annually, and under Formulary-Generic, the plan would indicate that there is NO maximum plan benefit coverage.

Example: The plan offers Formulary (Brand and Generic) drugs and has a $750 annual limit on the combination of drugs, but unlimited Generic after the limit is reached. The plan would designate that it has a maximum plan benefit coverage, and that this includes Combination of drug types. The plan would select Formulary Brand and Formulary Generic for the combination, and enter an overall limit of $750 annually. The plan would then indicate that Generic is unlimited after the combined max is reached.

Example: The plan has a $3,000 annual limit on drugs, with a $1,000 annual limit on Formulary-Brand and Non-Formulary Brand combined, and no individual limit on Formulary-Generic and Non-Formulary Generic. The plan would designate that it has a maximum plan benefit coverage, and that this includes All drug types covered by plan AND Combination of drug types. The plan would enter an overall limit of $3,000 annually, and a combination limit of $1,000 annually that includes Formulary-Brand and Non-formulary Brand in the combination.

In addition, if a plan only offers drugs with no distinction between formulary and non-formulary, the MCO should only answer questions relating to non-formulary drugs. SB

sentences will be generated that will not distinguish between formulary and non-formulary when the data is entered in this manner.

Authorization questions remain in the Prescription Drug Category. Written prescriptions from a physician are not considered to be an authorization for this category.

In the PBP2002, there is only one Notes field for this category that is located on Screen 5.

B-16a: Preventive Dental Services

The Preventive Dental Services subcategory has incorporated some new changes in the PBP2002. The MCO can have a single cost share for an Office Visit and designate the enhanced benefits that are included in that Office Visit.

Example: If the plan offers Oral Exams, Fluoride Treatments, Cleanings, and X-rays, and an Office Visit costs $80 and is comprised of an Oral Exam, Fluoride Treatment, and Cleaning, then under the Copayment, the MCO should select "Yes" to the question, "Is there a combination of services included in a single cost per office visit?". The MCO should then select Oral Exams, Fluoride Treatments, and Cleanings for the combination, and then enter $80 as the copayment amount for the office visit. Since the plan also offers X-rays, the cost sharing for this benefit should be entered separately.

B-16b: Comprehensive Dental

No major changes have been made for the PBP2002 in the Comprehensive Dental Services category. Data should be entered as was done for CY2001.

B-17a: Eye Exams

The Eye Exams category has incorporated a few significant changes. Additional wording will be incorporated into both the Summary of Benefits and in Medicare Compare more fully explaining the Medicare Covered Eye Exam benefit. In addition to the change for the SB and the MCC, adjustments have been made to the maximum plan benefit coverage data entry for Eye Exams and Eye Wear categories. Data elements in the Eye Exam and Eye Wear categories now allow for a maximum plan benefit coverage for either eye wear, eye exams, an individual maximum plan benefit coverage for each category, or a combined maximum plan benefit coverage for both categories.

Example: An MCO offers a $150 annual maximum plan benefit coverage for eye care. This includes both 17a-Eye Exams and 17b-Eye Wear. In 17a-Eye Exams Base 1, select “Yes” to “Is there a service-specific Maximum Plan Benefit Coverage amount?”, enter $150 and select "Every year". In 17b-Eye Wear Base 3, select “Yes” to “Is there a

service-specific Maximum Plan Benefit Coverage amount?", and for the next question, "Select the Maximum Plan Benefit Coverage type", select the option "Covered under Eye Exams Category 17a".

B-17b: Eye Wear

The Eye Wear category has incorporated a few significant changes. Additional wording will be incorporated into both the Summary of Benefits and in Medicare Compare more fully explaining the Medicare Covered Eye Wear benefit. In addition to the change for the SB and the MCC, adjustments have been made to the maximum plan benefit coverage data entry for Eye Exams and Eye Wear categories. Data elements in the Eye Exam and Eye Wear categories now allow for a maximum plan benefit coverage for either eye wear, eye exams, an individual maximum plan benefit coverage for each category, or a combined maximum plan benefit coverage for both categories.

Example: An MCO offers a $150 annual maximum plan benefit coverage for eye care. This includes both 17a-Eye Exams and 17b-Eye Wear. In 17a-Eye Exams Base 1, select "Yes" to "Is there a service-specific Maximum Plan Benefit Coverage amount?", enter $150 and select "Every year". In 17b-Eye Wear Base 3, select "Yes" to "Is there a service-specific Maximum Plan Benefit Coverage amount?", and for the next question, "Select the Maximum Plan Benefit Coverage type", select the option "Covered under Eye Exams Category 17a".

B-18a: Hearing Exams

No major changes have been made for the PBP2002 in the Hearing Exams Services category. Data should be entered as was done for CY2001.

B-18b: Hearing Aids

In the PBP2002, a new enhanced benefit has been added for Hearing Aids (all types), and Replacement Batteries has been removed as an enhanced benefit. The plan may select Hearing Aids (all types) OR one or more of the individual types of aids (Inner Ear, Outer Ear, and/or Over the Ear). If Hearing Aids (all types) is selected, then the MCO may NOT select an individual type of aid. There is a min/max cost share available for the plan to price Hearing Aids (all types).

B-19: POS

In the PBP2002, there is a new service category for a plan to enter POS benefits information. Previously in the PBP2001, the POS information was collected within each service category.

The POS category includes pick lists to enable the MCO to indicate which service categories include a POS benefit and, in addition, which of those categories require a referral and which require authorization.

If the plan indicates that there is a cost share for the POS benefit, the PBP allows the MCO to indicate if the POS costs are the same as non-POS, or if they are different by entering a Min/Max range. Due to SB 2002 requirements, there are separate cost share questions for Inpatient Hospital Acute and Inpatient Psychiatric Hospital benefits, if applicable.

SECTION D

Designation of Optional Supplemental Benefits Package

Section D is used to designate Optional Supplemental Benefits packages offered by the plan. Section D enables the plan to create one or more Optional Supplemental Benefit packages with an associated premium.

The plan selects one or more benefit subcategories enabled on the first screen based on benefits designated as Optional in Section B. Each enabled subcategory must be included in at least one Optional Supplemental Benefit package. In addition, the MCO may now also select, on a second screen, other service categories containing optional supplemental benefits within a designated package. This feature has been added so the plan can indicate benefit subcategories where the optional benefit has been described in the Notes field, e.g., step-up benefits. Optional supplemental benefits must be described in the service category Notes fields that correspond to the benefit. For example, if there is an Optional Supplemental Prescription Drug benefit then this benefit must be described in the Notes section of Section B, Category 15, Outpatient Prescription Drugs. If there is not enough room in the notes field of that category then the MCO should make a notation in that Notes field and further describe the benefit in the Notes field for Section D.

The MCO must enter the Premium amount for the Optional Supplemental Benefits package and select from the pick lists on screens 1 and 2 the set of service categories that describe the optional supplemental benefits included in that package. Note that a service category should only be selected once between the two screens, so it is not repeated in the list of service categories included in the package.

UPLOAD

Certification Statement

The upload now contains a certification statement. After industry input and further consideration by HCFA, the PBP Certification Statement will **not** be required. The PBP software will still require that the Certification statement be viewed and printed; however, HCFA is not requiring that the certification be signed or submitted.

If submitted, this statement should be signed with the required signatures, and should be sent in with the hard copy Adjusted Community Rate documents, including substantiation.

If the user's computer is not hooked up to a printer, a message box is displayed informing the user on how to copy the contents of the letter, paste it into Word, save it to a floppy, and print the letter from a different computer using the file on the floppy.

Summary of Benefits Verification

Upload requires a verification of the Summary of Benefits. The verification of the SB produces the document for upload and display on Medicare Compare.

HCFA Contacts

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